

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-009858

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 528

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 4000

2 223

3

4 0

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9 4200

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11

12 48-0

13

USE BLACK INK
OR
TYPEWRITER, RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY SAINT LOUIS | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JEFFERSON BARRACKS, MO | | c. CITY OR TOWN SAINT LOUIS | |
| Length of stay in 1b 3 DAYS | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL | | d. STREET ADDRESS (If outside, give location) 2226 INDIANA AVENUE | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JAMES Middle A. Last MC CONNELL | | 4. DATE OF DEATH Month FEB Day 18 Year 1963 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 5-7-93 |
| 9. AGE (last birthday) 69 YEARS | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY CEMENT | |
| 11. PLACE (City and state or country) EMINENCE, MISSOURI | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME WILL MC CONNELL | | 13b. MOTHER'S MAIDEN NAME MALENDIE RUSSELL | |
| 14. NAME OF HUSBAND OR WIFE LOU MC CONNELL | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-I | |
| 16. SOCIAL SECURITY NO. [REDACTED] | | 17. INFORMANT LOU MC CONNELL 2226 INDIANA AVENUE SAINT LOUIS MISSOURI | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 3 YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female, was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | | |
| 21. I attended the deceased from 2-15-63 to 2-18-63 Death occurred at 3:30 AM on the date stated above, and to the best of my knowledge, from the causes stated. | | 22a. SIGNATURE (Degree or title) RICHARD E. DANIELS, M.D. | |
| 22b. ADDRESS VA HOSP. JEFF. BRKS, MO. | | 22c. DATE SIGNED 2-18-63 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 2/20-63 | 23c. NAME OF CEMETERY OR CREMATORY ST TRINITY LUTHERAN | 23d. LOCATION (City, town, or county) (State) SAINT LOUIS, MISSOURI |
| 24. FUNERAL DIRECTOR MC LAUGHLIN FUNERAL HOME, INC | 25. DATE RECD. BY LOCAL REG. 2-18-63 | 26. REGISTRAR'S SIGNATURE [Signature] | |

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Licensed Embalmer No. 4559

P. O. Address D. L. Lauer, Md.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.